United States Department of Labor
Employees' Compensation Appeals Board

B.P., Appellant	)	
and	)	**Docket No. 09-507**
	)	**Issued: October 15, 2009**
U.S. POSTAL SERVICE, POST OFFICE, Roanoke, VA, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On December 12, 2008 appellant filed a timely appeal from a May 23, 2008 merit decision of the Office of Workers' Compensation Programs granting her a schedule award for a five percent permanent impairment of the right upper extremity. She also timely appealed a September 12, 2008 decision which denied further merit review. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merit schedule award decision and the nonmerit decision in this case.

ISSUES

The issues on appeal are: (1) whether appellant met her burden of proof to establish that she sustained more than a five percent permanent impairment of her right upper extremity, for which she received a schedule award; and (2) whether the Office properly refused to reopen her case for further review of the merits pursuant to 5 U.S.C. § 8128(a).

FACTUAL HISTORY

On May 1, 2003 appellant, then a 48-year-old mail processor, filed an occupational disease claim alleging that she sustained a repetitive motion condition in her right hand in the

performance of duty. She stopped work on March 30, 2003 and returned on April 30, 2003.[1] The Office accepted the claim for right carpal tunnel syndrome. It also authorized a release of the right volar carpal ligament, which was performed on December 4, 2002 and a reexploration of the right wrist on March 31, 2003. Appellant received appropriate compensation benefits.

On April 4, 2006 appellant filed a claim for a schedule award. In a June 28, 2006 report, Dr. George D. Henning, a Board-certified orthopedic surgeon and treating physician, noted that appellant reached maximum medical improvement six months earlier. He advised that she did not have any areas of ankylosis or major restriction of movement. Dr. Henning indicated that appellant had some pain and discomfort with complete flexion of her hand. Appellant had reduced grip strength and the ability to lift. Dr. Henning advised that appellant was able to tolerate working with a 35-pound lifting restriction for some time. There was no atrophy, decreased sensation in her hand to pinprick but some numbness and mild pain in her upper extremity. Dr. Henning opined that appellant had impairment of the right upper extremity "as a whole" of 10 percent.

In a letter dated August 15, 2006, the Office advised appellant that it had received Dr. Henning's June 28, 2006 report but requested that she obtain an assessment of permanent impairment from her physician based on the American Medical Association, *Guides to the Evaluation of Permanent Impairment,* (A.M.A., *Guides*) (5th ed. 2001).

In a September 5, 2006 response, Dr. Henning indicated that his prior report dated June 28, 2006 was "self-explanatory." He noted that appellant was working and had a minor restriction. Dr. Henning advised that she was "getting along just fine and this is all the wasted paper work we need to put into this case. If you want me to, I will send her to a neurologist and they can do a long complicated workup for you if you desire."

On March 30, 2007 the Office referred appellant together with a statement of accepted facts, a set of questions and the medical record, to Dr. Shubha A. Chumble, Board-certified in neurology and psychiatry, for an impairment evaluation.

In an April 25, 2007 report, Dr. Chumble reviewed appellant's history of injury and treatment. She determined that appellant had very mild right hand grip weakness and sensory deficits in the right index finger and thumb and advised that the neurological deficits were in the right median nerve distribution. Dr. Chumble indicated the numbness at the tip of the right little finger could not be explained based on a median nerve injury and had questionable significance. She noted that a repeat nerve conduction study might show whether appellant had worsened. Dr. Chumble concurred with Dr. Henning and opined that appellant had 10 percent impairment of the right upper extremity and had reached maximum medical improvement.

In a July 27, 2007 report, the Office medical adviser reviewed the medical evidence which indicated that appellant had 10 percent impairment of the right upper extremity. He noted that Dr. Chumble did not specify how she arrived at 10 percent impairment. The medical adviser explained that the examination was normal with the exception of mild weakness of the right hand

[1] The employing establishment also noted an earlier work stoppage date of December 1, 2002 and a return to work date of January 9, 2003.

grip and some numbness of the fingertips. He noted that Dr. Henning did not explain his rating by referring to any specific table or charts in the A.M.A., *Guides.* The Office medical adviser noted that there were no diagnostic studies or other evidence by which to calculate the percentage of impairment in accordance with the A.M.A., *Guides.* He opined that appellant reached maximum medical improvement on March 31, 2004, which was one year after the second carpal tunnel surgery. The Office subsequently scheduled appellant for an electromyogram (EMG) scan with Dr. Chumble.

In a September 5, 2007 nerve conduction and EMG scan, Dr. Chumble noted that right median nerve stimulation revealed that appellant had prolonged distal latency of 4.5 with a normal amplitude but low conduction velocity of 42.3 and right ulnar motor nerve stimulation, which was normal. No response was elicited on stimulation of the right median sensory nerve and the right ulnar sensory nerve tested normal. Dr. Chumble advised that the study was indicative of right carpal tunnel syndrome and was essentially unchanged from a 2002 study.

On December 18, 2007 the Office forwarded the September 5, 2007 diagnostic studies to the Office medical adviser. In a December 20, 2007 report, the Office medical adviser noted that updated EMG and nerve conduction studies were performed which revealed the persistence of the carpal tunnel syndrome. He indicated that there was "nothing in the medical record to indicate any abnormality on physical examination." In light of a normal physical examination and the persistence of an abnormality on diagnostic studies, appellant had five percent impairment of the upper extremity under the A.M.A., *Guides*.[2] The Office medical adviser found that appellant reached maximum medical improvement on December 4, 2003.

In a March 24, 2008 report, Dr. Henning set forth work restrictions and indicated that appellant had moderately severe carpal tunnel syndrome on the right. He did not address permanent impairment.

By decision dated May 23, 2008, the Office granted appellant a schedule award for five percent permanent impairment of the right upper extremity, for a total of 15.60 weeks of compensation. The period of the award was December 4, 2003 to March 22, 2004.

In a letter dated June 16, 2008, appellant requested reconsideration. She indicated that the award was based on maximum medical improvement from the first surgery; however, she had a later surgery on March 31, 2003. Appellant questioned why the 10 percent impairment estimates provided by Dr. Henning and Dr. Chumble were not used.

By decision dated September 19, 2008, the Office denied appellant's request for reconsideration without further review of the merits. It found that she neither raised substantial legal questions nor included new and relevant evidence. Appellant's request was insufficient to warrant review of its prior decision.

[2] A.M.A., *Guides* 495, Chapter 16.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provision of the Federal Employees' Compensation Act[3] and its implementing regulations[4] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss, or loss of use, of scheduled members or functions of the body. However, the Act does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[5]

The fifth edition of the A.M.A., *Guides*, regarding impairment due to carpal tunnel syndrome, provides:

> "If, after an *optimal recovery time* following surgical decompression, an individual continues to complain of pain, paresthesias and/or difficulties in performing certain activities, three possible scenarios can be present:
>
> > 1. Positive clinical findings of median nerve dysfunction and electrical conduction delay(s): the impairment due to residual [carpal tunnel syndrome] is rated according to the sensory and/or motor deficits as described [in Tables 16-10a and 16-11a].
> >
> > 2. Normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal [electromyogram] testing of the thenar muscles: a residual [carpal tunnel syndrome] is still present and an impairment rating not to exceed five percent of the upper extremity may be justified.
> >
> > 3. Normal sensibility (two-point discrimination and Semmes-Weinstein monofilament testing), opposition strength and nerve conduction studies: there is no objective basis for an impairment rating."[6] (Emphasis in the original.)

The Board has found that the fifth edition of the A.M.A., *Guides* provides that impairment for carpal tunnel syndrome is to be rated on motor and sensory deficits only.[7]

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[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404.

[5] *Id.*

[6] A.M.A., *Guides* 495.

[7] *Kimberly M. Held*, 56 ECAB 670 (2005).

ANALYSIS -- ISSUE 1

The medical evidence of record establishes that appellant has no more than a five percent impairment of her right upper extremity. On appeal, appellant questions why she did not receive a schedule award for 10 percent impairment as recommended by Drs. Henning and Chumble. She also questions her schedule award started in 2003 and was based on her pay in 2002.

On June 28, 2006 appellant's treating physician, Dr. Henning noted that appellant reached maximum medical improvement six months earlier. He found that appellant did not have any ankylosis or major restriction of movement although she had some pain and discomfort on flexion of her hand. Dr. Henning also noted that appellant had reduced grip strength. He advised that there was no atrophy, decreased sensation in her hand to pinprick but some numbness and mild pain in her upper extremity. Dr. Henning opined that appellant had impairment of the right upper extremity of 10 percent. However, he did not explain how he derived this impairment rating under the A.M.A., *Guides*. When the Office requested that Dr. Henning provide a report that complied with the A.M.A., *Guides,* he responded on September 5, 2006, that his rating was "self-explanatory." The Board finds that the impairment rating of Dr. Henning is of limited probative value as he did not properly rate impairment under the A.M.A., *Guides*.[8]

The Office subsequently referred appellant for a second opinion examination with Dr. Chumble. However, Dr. Chumble's opinion regarding permanent impairment also did not conform to the A.M.A., *Guides*. She concluded that appellant had 10 percent impairment of the right upper extremity; however, she did not refer to or indicate that she had utilized the A.M.A., *Guides.* Dr. Chumble did not list any tables, figures or pages relied upon to make her rating. Thus, her report is of limited probative value without any explanation of how she arrived at her conclusion pursuant to the A.M.A., *Guides*.[9]

The Office further developed the claim by obtaining updated diagnostic testing from Dr. Chumble. Following this, the Office medical adviser reviewed appellant's history of injury and treatment and utilized the A.M.A, *Guides*.[10] He noted that appellant underwent carpal tunnel release on December 4, 2002 and that an updated EMG and nerve conduction studies were performed on September 5, 2007, which revealed the persistence of the carpal tunnel syndrome. He concluded that there were no abnormalities on physical examination. The Office medical adviser noted the persistence of an abnormality on the EMG and nerve conduction studies. He concluded that she had impairment of five percent to the upper extremity under scenario II on page 495 of the A.M.A., *Guides*.[11] He found that appellant reached maximum medical improvement on December 4, 2003.

[8] *Shalanya Ellison*, 56 ECAB 150, 154 (2004) (schedule awards are to be based on the A.M.A., *Guides*; an estimate of permanent impairment is not probative where it is not based on the A.M.A., *Guides*).

[9] *See id.*

[10] A.M.A., *Guides* 495, Chapter 16.

[11] *Id.*

The Board finds that the Office medical adviser's December 20, 2007 report is sufficiently rationalized to establish that appellant has no more than five percent permanent impairment of her right upper extremity. Therefore, the Board will affirm the Office's finding on the degree of appellant's permanent impairment. Appellant has not submitted any other medical evidence conforming with the A.M.A., *Guides* establishing that she has greater impairment.[12]

The Board finds, however, that the weight of the medical evidence does not support the Office's determination of a retroactive date of maximum medical improvement. The Office's May 23, 2008 schedule award decision found that appellant reached maximum medical improvement on December 4, 2003, less than one year after her March 31, 2003 surgery. The Board notes that a retroactive date for maximum medical improvement carries with it certain disadvantages and may result in payment of less compensation. Therefore, the Board has been reluctant to find a date of maximum medical improvement which is retroactive to the award and requires persuasive proof of maximum medical improvement in the selection of a retroactive date.[13] The determination ultimately rests with the medical evidence.[14] Maximum medical improvement is generally considered to be the date of the evaluation by the attending physician which is accepted as definitive by the Office.[15] In the instant case, the date of the examination upon which the March 23, 2008 schedule award decision was the updated diagnostic testing of September 5, 2007 and the Office medical adviser's December 20, 2007 report. The Office medical adviser indicated that appellant reached maximum medical improvement on December 4, 2003. However, the first Office medical adviser placed the date of maximum medical improvement as March 31, 2004, one year after the second operative procedure. Additionally, Dr. Henning opined that appellant had reached maximum medical improvement six months prior to June 28, 2006. On April 25, 2007 Dr. Chumble indicated that appellant had reached maximum medical improvement; however, she did not give a specific date. The Board finds that, as an examining physician, the report of Dr. Henning is most probative as to the date of maximum medical improvement. Dr. Henning specified that it was reached as of January 28, 2006.

[12] The Board notes that appellant retains the right to file a claim for an increased schedule award based on new exposure or on medical evidence indicating that the progression of an employment-related condition, without new exposure to employment factors, has resulted in a greater permanent impairment than previously calculated. *Linda T. Brown*, 51 ECAB 115 (1999).

[13] *J.C.*, 58 ECAB ___ (Docket No. 06-1018, issued January 10, 2007). *See Joseph R. Waples*, 44 ECAB 936, (1993) (for a retroactive determination of the date of maximum medical improvement, the burden is greater on the Office to show that the retroactive date is, in fact, the date of maximum medical improvement because of the adverse effect a retroactive determination may have on the employee; the evidence must be strong enough so that it "clearly and convincingly establishes that maximum improvement had in fact been reached by that date" (quoting *Marie J. Born*, 28 ECAB 89, 94 (1976)).

[14] *L.H.*, 58 ECAB ___ (Docket No. 06-1691, issued June 18, 2007).

[15] *Mark Holloway*, 55 ECAB 321, 325 (2004).

CONCLUSION

The Board finds that appellant has no more than a five percent permanent impairment of her right upper extremity. The Board also finds, however, that the date of maximum medical improvement was January 28, 2006.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated May 23, 2008 is affirmed, as modified.

Issued: October 15, 2009
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board